SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
STATEMENT OF INDIVIDUAL DECLINING PDD STATE FUNDED SERVICES

Please Type or Print

Individuals Name:_____

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___
1 2 3 4 5 6 7 8 9

I, _____, as recipient/legal guardian of recipient/family member of recipient, have decided at this time to not pursue enrollment in the PDD State Funded Program. I understand that declining participation now does not prohibit me from reapplying for the PDD Program in the future should my child meet all requirement criteria.

I understand that this decision does not directly affect my eligibility for other services available through the South Carolina Department of Disabilities and Special Needs.

_____ _____
Individual/Legal Guardian Date

_____ _____
Service Coordinator/ Early Interventionist Date

SAMPLE

Original: File Copy: Consumer/Legal Guardian and District MR/RD Waiver Coordinator